

[Date]

[Insurance Company Name]
[Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Initial Prior Authorization Request for Elective Rotator Cuff Repair

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Case/Reference Number: [If applicable]

To Whom It May Concern,

I am writing to request prior authorization for an elective rotator cuff repair for the above-referenced patient. This procedure is medically necessary to restore function and alleviate chronic pain that has failed to respond to conservative management.

Requested Procedure:

CPT Code: [Insert CPT Code, e.g., 29827 - Arthroscopy, shoulder, surgical; with rotator cuff repair]

Diagnosis Code: [Insert ICD-10 Code, e.g., M75.121 - Complete rotator cuff tear or rupture of right shoulder]

Clinical Documentation:

- **Symptoms:** The patient presents with [Duration] of shoulder pain, weakness, and decreased range of motion.
- **Imaging Results:** An MRI performed on [Date] confirms [Full/Partial] thickness tear of the [Supraspinatus/Infraspinatus] tendon.
- **Conservative Treatment History:** The patient has completed [Number] weeks of physical therapy, [Number] corticosteroid injections, and trial of NSAIDs without significant improvement.

Provider Information:

Surgeon Name: [Physician Name]
NPI Number: [NPI Number]
Facility Name: [Hospital or Surgery Center Name]
Tax ID: [Facility Tax ID]
Scheduled Date of Service: [Date]

Included with this letter are the office notes, physical therapy progress reports, and the radiologist's MRI report. Should you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Title]

[Practice Name]